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Date: 1/7/2026

Event: Long-Term Services and Supports Subcommittee Meeting

>> MATT SEELEY: It is 10 hours. Well good morning everybody.
>> MATT SEELY: Can you hear me? Can you hear me? ? I can hear you.
>> MATT SEELY: Good morning everyone, happy 2026. Here we are. We here for the LTSS subcommittee, if you are here for that you are in the right place I guess. Anybody out there knows what they're doing, do we do anything before housekeeping?
>> JULIET MARSALA: You go through the list of the panelists and the members of the LTSS subcommittee that are here.
>> MATT SEELY: Awesome. So this will be law from the beginning so bear with me. Is everybody ready for this? I'm here first on Alice, Abigail Foster. I will keep going, if anybody comes in after the fact, let someone know what let me know, Allie Crombie.
>> I'm here happy there.
>> MATT SEELY: Have a beer. If I murder your name, please forgive me, I will learn it. Andrea Costello. ? I am here.
>> MATT SEELY: Good morning. Carol Murphy's E.
>> I am here.
>> MATT SEELY: Good morning. Cody Jones.
>> I am here.
>> MATT SEELY: Good morning, Neil Brady. George Fernandez. Jenny Rogers.
>> Good morning, I am here.
>> MATT SEELY: Good morning Jeannie. J harder.
>> Good morning , Matt.
>> Good morning J. Kathy Kubik.
>> Good morning. I'm here.
>> MATT SEELY: Laura Lyons .
>> We have a thumbs up that she is here.
>> MATT SEELY: Good morning Laura and good morning whoever set. Linda Whitten. Lloyd Wertz . I am hoping Lloyd gets here. Lynn Weidner.
>> Good morning, I am here.
>> MATT SEELY: Good morning Lynn. Michael Galvin. Shall Garrett . Monica for Carl.
>> Good morning, I am here.
>> MATT SEELY: Valley stillness.
>> Good morning, I am here. I guess Pam Wells is excused, so, I'm sorry with this one. Rebecca McTaggart.
>> I am here.
>> MATT SEELY: Good morning. So next, I'm going to do the housekeeping. Because this is my favorite part every day. Housekeeping committee will select this meeting is being recorded, participation at that meeting your consent to being recorded. Point of order this meeting is being conducted as a webinar with remote screaming, to comply with logistical agreements we will end promptly at 1:00 p.m. to avoid background noise please keep your devices muted the microphones off unless you are speaking. Close captioning is available at every meeting the car

to captioning meeting is on the agenda I saw it already, for anyone who needs it you can look at that. It's on the agenda and in the chat, very important for only one person to speak at a time. State your name before commenting and speak slowly and clearly so that capture can capture conversations and identify speakers. Hopefully you all know my voice by now. If you don't, I'm sure you will get tired of it by the end of the meeting. Questions and comments, please keep your comments and questions concise to allow for everyone to be heard, webinar attendees may submit questions and comments into the questions box, forgo to ever use the base to Peter and put in the queue to speak life. In public comments Tom allotted is for to public comment periods, your questions or comments that were not heard please send them to the resource account email found at the bottom of the meeting agenda and the LTSS subcommittee. That is not. So agenda. January 7, January 7, 2026, were here for our January meeting. The call of order we did the housekeeping so I will pass it off to Julia.
>> JULIET MARSALA: Thank you Matt. I did want to recognize that and what height is here. For the updating of the local.
>> MATT SEELY: Good morning Anna.
>> JULIET MARSALA: Happy new year everyone. I appreciate everyone logging on here with us today. I want to start off our meeting and are competing if we can with a quick moment of silence for the lives lost in that tragedy of the Bristol nursing facility that occurred on December 23. And we know that there were three lives taken from us too soon there were also many other residents and direct care workers and facility staff that were impacted by the tragic events at Bristol. But we also have a huge outpouring of support and help and assistance and call to action from our emergency responders , from members of the community that were immediately surrounding the nursing facility, and emergency response effort led by our sister agency that the department of health . And that work continues but I did want to start off with a brief moment of silence. So thank you. If we go to the next slide I have quick updates on our agenda for everyone. Usual procurement updates, we will talk about participant self-directed fee schedule. And provide information on the rural health award. Before I get into that the Ido in our last meeting we talked quite a bit about the general budget state budget that was enacted for this fiscal year and I received a lot of really great questions and I've also received letters about the budget, suggestions, about the budget. But I want to go over really quickly some clarifications about the budget based on information I've seen and information that's been received and it seems like perhaps some additional clarifications would be beneficial so our folks and our stakeholders fully understand the state budget impact and the federal budget impact on the Department of human services and some of that impact on the office of long-term living. So I will start with the state budgets . Now, in particular I want to point out that yes if you look at last fiscal year to this fiscal year , and you look at the numbers between the budget from last fiscal year and this year, you do see the potential conclude that there was a 10% increase in funding. However, that does not mean that DHS or the office of long-term living is fully funded. We are in fact considerably short of the funding we need to have maintained our programs as they were operating in the last fiscal year. And the way you see that is if you look at the blue book of the Department of human services, and what was submitted as our budget ask, as our budget information of what we need to for example, continue community health choices as it was last year and expecting additional monies to cover the growth of new people needing services and enrolling in our programs, at the current level of services. So when you look at the blue book for DHS and the Medicaid programs, compared to what is enacted in the budget, you would see that the state budget reduced what DHS asked for as needed to continue our programs by a little over $1 billion. And more specifically, that reduction of $1 billion from our identified need ,

the majority of that was taken from the allegations that would have been used for CHC capitation, the PM Seo capitation, so specifically for the office of long-term living, and art CHC allocation, if you look at our blue budget book compared to what is enacted, you may have seen approximately $280 million was reduced from the original amount that we put forward as estimated as needed to serve all the participants within CHC that are currently in place, and thus we expect to end. So all is to say, we did not get a 10% increase, we don't have an extra 10% of funds that we could utilize however we want. We actually had to determine, figure out, and make really difficult decisions on how we address the approximately $280 billion shortfall. From our needed program resources. We did receive a one-time investment as part of the enacted budget predominantly from the lottery funds. A letter over 120 million for a one-time investment to mitigate the shortfall. In addition, as we talked about in September, we needed to look at the entirety of the Medicaid program. We made changes as you heard from the MAAC meeting as you may have seen from the Medicaid bulletin, we made significant changes to the TLP one, and other pharmaceuticals to help us mitigate that gap specifically ending the coverage of GLP one ending the coverage of GLP 14 weight loss and management. In CHC, we also adjusted down quite significantly funds that would have otherwise been available to help support our CHC CEOs in their pay for performance opportunities for the areas of innovation, and important that RN in the CHC agreements. That was another area we had to adjust downwards to mitigate the losses. And we did these , you know because they are the least sort of impactful, the least of the bad decisions that we could that particular point in time. Facing a budget shortfall means that you know, often times we have to look at very difficult decisions and try and determine which one is sort of perhaps the least of the worst. Which is an unfortunate position to be in. So that is the state of the state budget for this fiscal year, just a little bit of clarification. I also want to point out in HR one, just as a reminder, the state budget, starting in 2028 is when we will feel the full impact of HR one. And OB three, and that is when we start feeling the estimated impact of the total of $20 billion in reductions to the Commonwealth Medicaid program. Which would be estimated in about a reduction of $2 billion each fiscal year in federal funding. So we are facing that cliff. Certainly a lot can change between now and 2028. But this is the year we will be beginning to have those conversations in preparation to make the least awful position that we can. As we move closer to 2028 and you know, fairly soon you will hear from DHS at large about the stakeholder engagement activities that we will be rolling out . However, a lot of those discussions, we will also be looking to have as part of the LTSS subcommittee in this calendar year. In particularly making use of our public comment periods, and certainly the office of long-term living welcome submissions and ideas from our stakeholders at any time, however, given our restraint in resources, we certainly welcome all the input, and the letters we receive, and email correspondence we receive, we know we are all in this together, the ability to have separate meetings with each individual stakeholder group just is not necessarily feasible given our resource constraints. So as we roll out the stakeholder engagement opportunities, we really do hope you will participate in those opportunities. As much as possible. So let's go into the next slide. Procurement update, there are no updates in the community health choices RFA, it will continue to operate under the current CHC care organizations. And the new current agreements until further notice and there is no activity pertaining to the RFA occurring at this time. And your questions can still be sent to the RFA email. Resource account at RFA – P WF RA questions – pwfraquestions@pa.gov. Go to the next slide. We did have a win in the budget. For participant self-directed fee schedules. The fiscal , the budget enacted and signed into law November 12, 2025 included $21 million investment to strengthen the workforce to increases in wages for direct care services in the

participant model for LTL programs. This additional funding provides for rate increases in the OBRA and act 150 program. For personal assistance services so that is specifically the procedure codes W 1792, and W 1790 2TU which will be effective and retroactively to January 1, 2026. There was a listserv on December 19 that was released notifying the service coordinators of the rate changes that are in progress, the claims processing and provider enrollment. The preparation work needed to put these investment advice and fee for service. What is important to know, is that we are excited about this investment for direct care workers, it's a critical investment. And we want to work as quickly as we can to get this funding out through our systems. To that direct care workers. That this product is intended to support. There are administrative procedures that we have to go through which is why we will be able to go retroactive to January 1 but you are not seeing that in effect now, there will be delays because of how long the budget Doug to be enacted. For us to go through all of our requirements with updating the fee for service fee schedule notifying and obtaining approval from CMS, getting communication pieces in place, and working as fast as we can to implement these changes for everyone. So we go to the next slide. So OLTL will provide the common-law players and fee-for-service program and automatic often to an hourly rate increase once we get all those communications in place, and we receive CMS approval. They have indicated they will also align and utilize a similar approach. So when everything is in place, and we receive CMS approval, and that the schedule update is published and go through the regular public comment process, this is all is not my team is working really hard to do. The common-law employers should not have to do anything for their employees to receive up to the 9.09 estimated percentage increase. Matt is the required costs related to employer costs. I would be indicated by the fee for service schedule once it is fully approved and fully in place. So you guys are getting sort of a preview of information. The common-law employers will have through the end of January 2026. It may be extended depending along it takes to get out required approvals. To always provide your preferences to the wages that direct care workers receive. Common-law employers by the employer of Acord. They are the only employer and they are the individuals that make choices about wages as they do at any point in time. Up to the maximum wage allowable per the reimbursement restraints. Okay. So this is what we anticipate to be the roadmap. Again, that it may change . That team is working with our FMS partner GPL to put together the communication in anticipation of trying to work as fast as we can. Once we get the requirements completed with regard to CMS approval, public notice etc. So, I just want to get a preview because I thought it was important that folks understand what is happening. What to look for, and you know that it will be retroactive to January 1. We just can't release anything until we receive the appropriate approvals which were a result of the delay in the budget approval. We go to the next slide. All right. So, I went through some of this. Information for common-law employers. When that information is available, it will be accessible by the fiscal employer website. For that fee-for-service folks, this is a reminder, it's PA OLTL portal for CAC programs, it is the website Pennsylvania's Tempest United, the CHC MCL and Tempest are also preparing their communications again, we are waiting for the appropriate authorizations to occur. Next slide. Starting off 2026 with some good news with the CMS rural health awards on December 29, CMS announced by a press release that all 50 states received awards under the rural health transformation program. That was a $50 billion initiative to strengthen and modernize healthcare in rural communities across the country. In 2026 states will receive the first year were awards from CMS which averaged around 200 million. States received a range of 100-4792 200 States received a range of 100-4792 200 million. Pennsylvania was in the middle of the back and we received 193 193 million and change. So this federal investment will help us extend access to

care in rural communities. It will strengthen our rural health workforce, modernize world facilities and technology and support innovative models that bring high-quality care closer to home. We expect to receive funds, allocations over the next five years in 2026 to 2030. Additional information on Pennsylvania's plan can be found at the rural health Department of human services Commonwealth of Pennsylvania website. That week Willie in the materials we put out. But you can also open up your browser if you key in these keywords, you will likely get to that website fairly quickly. I know there's a lot of excitement about these rural health awards, I certainly am excited. The OLTL team will be working very hard and collaborating along many of the initiatives particularly those around the aging and disability populations including the age expansion of our life program. Including further integrating our dual eligible populations. There's a lot of good stuff in the Pennsylvania plan and application submission, so I invite you all to take some time to take a look at it. The OLTL is not the lead office for the world health. We are certainly a partner and collaborator, so you know, certainly would again encourage folks to go to the website. Where information will be put out with regards to how to connect into the rural healthcare transformation efforts. We go to the next slide. I wanted to take a moment to recognize Michael Hail who has officially retired from the office of long-term living as of January 2. He began work in our field back in 1979 and has a very rich and impactful 47 years of allocating and serving older adults and people with disabilities , and really legendary and helping to enact, stand up, and support many programs that have had huge impacts on the independent living for people with disabilities and our older adults to have choice in how they live or play , love, and age with dignity. He started with the Commonwealth in 2007. He has left us some really big shoes to fill. But thankfully he was also an incredible leader , an incredible mentor, and has spent many years entering that we have a very strong bench here at the office of long-term living, so I wanted to take a moment to really share this monumental change. To congratulate him in his retirement and wish him well. And also to announce that Kim barge who has worked very closely with Michael Hail in the Bureau of fee for service, has graciously accepted the Bureau director of the fee for service programs. And so, she will be taking the helm and captaining the ship. And we have no doubt that she will be so amazing in her role as she settles into it in this new year. We go to the next slide. I think I'm at the point of questions and I apologize I might be a little behind on the agenda. Matt? Any questions?
>> MATT SEELY:I do not have any. But thank you Juliet. Mike, congratulations. Well-deserved and I have to say I love the fact you started in 1979, I was five years old. Anyway. Are there any questions for Juliet.
>> This is Monica from the baited injury Association. Have a question for Julia. Julia, for that direct care rate increase, can you comment on how that will or if it will impact the direct care workers in residential rehabilitation programs.
>> JULIET MARSALA: It will not mom the money appropriated by the Gen. assembly was specific to direct care workers care assistance attendance and the participants self-directed. Model of services.
>> And I know I said this before but you go on record, this is a big issue for the brain injury committee and I know you are aware of it and are looking into it, but I wanted to say it again.
>> JULIET MARSALA: Absolutely, I appreciate you raising that up. I think what is really important and certainly in the office of long-term living, 100% recognizes based on the wage study that was conducted and that we publish, in addition to hearing from all of you, often, we don't disagree with you, where we need support as an office is having his many people as possible really educate our representatives and so I appreciate you raising it here. I would encourage folks to spend time with representatives because you know, Medicaid is very

complicated. It's not necessarily easy to understand. And the applications are not necessarily easy to understand either. So anything that folks can do to ensure that there is education, of our representatives and their staff, I think that would be beneficial, Monica, to helping to further address the needs particularly of direct care workers in residential rehabilitation facilities, agencies, adult day centers, across-the-board, our front-line workers are critical and essential to continuing the six as an independent living meeting the needs of older adults and people with disabilities.
>> And brain injury coalition, we work closely with the Caucus and state legislature, and we made them well on multiple occasions will continue to do so.
>> MATT SEELY: Thank you. Any other panelist have any questions? I can see. It says hands are up but I'm not able to see who they are.
>> This is Jeannie, Matt, can I go! Go ahead.
>> I also wanted to congratulate Michael Hale, thank you Michael for your years of service, I met Mike back in the early 90s, when I was also working as a center for independent living, so congratulations Michael some also welcome Kim, I know you will be great and noble, so good luck to you. I also want to echo what Monica said about the wage rates, and certainly very happy to hear about the participant wage rates for sure. But we still have a long way to go. I am interested we are doing a legislative reporter. But I am interested in what was the winning argument for getting the wage rate increases for participant direction , and not for the other side of home care agencies for example. I will stop there, I wanted to register that information.
>> JULIET MARSALA: Absolutely and thank you for that. I can say I don't know. I was not at the budgeting table. So I will, you know sort of this role, take the win, and enact the administrative duties that are set forward to me as best I can and as best as our team again. So, I am sky I don't have the answer to that. If I did, I would let you know.
>> MATT SEELY: There are three other questions.
>> There are two questions from members. Lynn Whitener and Jane Harner, and I do have three questions in that chat when you are ready.
>> MATT SEELY: Let start with J.
>> JAY HARNER: This is not a question, more of a comment about the rural investment of $50 billion. I know that's a talking point we need to make a statement that almost $1 trillion was cut to Medicaid the federal government. In the estimates are between 10 and 20 million people are going to lose their Medicaid insurance in the next 10 years with ups was nice to get $190 million back to Pennsylvania, $1 trillion is very significant and will impact more people in the rural healthcare in the long run. The one thank you. Lynn. I'm sorry, you were done J?
>> JAY HARNER: Yes thanks Matt.
>> MATT SEELY: Lynn?
>> Thank you. I just wanted to say that as a participant directed caregiver, I am very excited about the raises and also on the half of my participant who often listens and it is usually in the back on someone, he is also glad about the opt in. And he wants to know more about how the notifications will be sent out. Given that you are saying the end of January is coming up pretty quick. Should he expect mail or a phone call? How is the notification going to be given out to the participants so they can , you know, make sure they have their budget straight. And also, as a caregiver I'm also glad to hear it will be retroactive starting January 1.
>> JULIET MARSALA: Thank you Lynn. Good question. The teams are finalizing all of that final information so I don't have the specific details for you, but as I said, those were preliminary dates. The dates will change, we want to injure the common law employers they will have time to be notified and evaluates why would not hold the end of January date. It will most definitely

be 30 days from the date this communications start going out. We don't know exactly when that date will be. We thought it would be sooner than later. It seems like it will be a little later. So that end of January date, don't hold me to them. It will be at least 30 days from when communications start going out and we received the actual approval. Soper books, really looking out the timing of that, when the bulletin with the fee schedule goes up, that's when things will start really ramping up. Communications, I believe will go out through the portals in the fee for service, text messages, Robo calls and those sorts of things. Sort of similarly major to how you routinely receive your common-law employer information. And folks, absolutely can go and check the website and things of that nature. I encourage you to do so for those updates periodically through January. And we will certainly put things out to the listserv and it's also where expectation that SEs will help amplify the message and major folks are aware, and that's another reason why we think that the automatic opt in, we think you know, based on the past history and feedback that we've received from our stakeholders , you know, the opt in automatic increase was welcomed by the majority of CLV, and they recognize they had control of wages, and they could choose not to implement an increase if they wanted to at any time because they could make changes at any time. In addition, we think that this methodology of distribution is in the best public interest because it reduces the administrative burden. Of folks. It helps to enact the changes very quickly and the direction we have most often heard folks want increased wages. They want their direct care workers to be recognized as deserving which they are. Of increased wages. So that's the reason why we've gone with this process so that if there's any difficulties , or delays in communication etc., or a CLV will miss a text string a Robo, it will not have a detrimental effect to them or the direct care worker and they can make adjustments at any time if they wanted to. I hope that helped.
>> MATT SEELY: Thank you Juliet. I still see one more question here.
>> Hi Matt, Natalia Gomez, new member has a question.
>> MATT SEELY: HI Natalia.
>> .
>> MATT SEELY: Can I ask you to speak up a little bit.
>> Can you hear me better?
>> MATT SEELY: That’s much better thank you.
>> I have a question at a statement. I use to self-correct . My question will be I know I've been visiting the webpage to get the updates, , the new rates have not been put on the page. My question. And if not,
>> JULIET MARSALA: They have not been published yet, we are giving you a preview. The fee schedule needs to be abolished in the public Pennsylvania bulletin. So that is in process. It has not been published yet. In addition we need CMS approval. We expect that fairly quickly, soon after we get through the public posting process. So no information is up yet because nothing has been approved yet. This is a preview and anticipation because we did not want folks to just wonder what was happening.
>> Okay, I used to be self-directed and I know $11 an hour even with the one dollar increase, that was not realistic for my caregivers. Which prompted me to go to the agency model. So looking forward to seeing if it does make a difference because when I went into a hypothetical type of numbers, it didn't seem to be that big of a difference. So that was my concern so therefore by Ginny, I hope the money is used for they caregivers participants benefit rather than the agencies. I know you will get a lot of those questions, Julia, when things go out there, and the administrators, those are food for thought we are throwing out.
>> JULIET MARSALA: Thank you Natalia, I appreciate the question.

>> MATT SEELY:I see two more questions. One more.
>> Next question would be from Cody Jones. You.
>> Hi Cody Jones, Pennsylvania home care Association. One quick question and a follow-up. Are you all projecting an increase in movement from agency directed to participant directed based on the new rates?
>> JULIET MARSALA: We are not. Ginny, the new rates released do not account for any sort of movement from direct care workers from agency to participant directed?
>> JULIET MARSALA: No. So here's the thing with that, Cody, participants moving from agency model to participant self-direction, the financial analysis of that or the financial impact of that is when a participant moves from agency model to participant self-direction, because of the rates, if you look at the straight rates, the program is actually have potential savings when individuals select participant self-direction. So if there was movement which we can read it. Right? Because we don't know what will happen. But if there was movement and growth was participant self-direction, the program's overall should recognize and overall program savings. At just the way the rates of oregano. The increase in rates in participant self-direction doesn't change that dynamic. It still would capture a savings from overall in our Medicaid system . The other thing to note as you know Cody and the CHC agreements that have been there for quite a number of years, participant self-direction is the first preferred option because it gives participants the most control. Over there support team and their direct care workers. And utmost independence in decision-making, so it's most in line with those independent living goals and values. So participant self-direction continues to be the first option that should be provided and levers option that direct care workers should be educated on. Each model has benefits, each model has different challenges. But no, we did not expect nor anticipate a huge influx of changes in models. You know, nothing out of the ordinary.
>> CODY JONES: You have to excuse me, I'm wrapping my head around everything because after year and five months I consider myself new to this complicated world. But going back, is that inclusive of overtime invade was that a separate discussion?
>> JULIET MARSALA:I believe it inclusive of the program overall.
>> CODY JONES: Okay.
>> JULIET MARSALA: When there's an analysis done a comparison of agency model and participant directed model, our team, took the model in totality so they're not just looking at straight time versus overtime. That would not break analysis.
>> CODY JONES:I appreciate that. Thank you.
>> MATT SEELY: This is not "Cody, just to tell you quickly, I'm sure you're not the only one that had the question. He said there were questions in the chat?
>> Yes there are, before we continue, I want to let everyone know that Abigail Foster and Lloyd Wertz have joined. And if you're ready, I can go to the questions in the chat. I met her where we stand with the agenda and timewise.
>> MATT SEELY: It looks like we have 10 more minutes or sorry five more minutes. So if we have a couple, let's try to handle them.
>> The first question is from Ashley Wright. Regarding the RH TEP, how does the department envision expanding 988 services, and continuing education on 988?
>> JULIET MARSALA: Ashley, that is a great question. 988 is vital and important and poor folks were not aware of 988, it is a national mental health crisis and support line. As an alternative to 911. 988, those folks are there to really help support and address mental health needs and mental health crisis and it's extremely important. That is a better question for the rural health transformation team, certainly information on the website, and certainly information you know

that will most likely be led by
[INDISCERNIBLE]
I'm not the best person to get into the weeds on that, but certainly we can give it additional information after LTSS FAQ, and if you look in the transformation plan application, you might see additional information. Remember this is your one. So, getting into the weeds of our HTP, this is the year we will build out those meatier work plan. But great question. And we will follow up as best we can with my team getting an answer from folks who can't speak more eloquently to get them high.
>> This is Paula. The next question is from Jeff Eiseman. Can you re-clarify on the rate increase regarding retroactivity? How soon will this be implemented , and it's only for six months of the fiscal year 2025 through 2026? Is that correct?
>> JULIET MARSALA: Great questions, Jeff. So the rate increase would be on the fee for service side for participant self-direction, is currently estimated to be 9.09 % above the current max rate. That accounts for overtime, F map, I was utilized, – – hours utilized, the standard projection of growth in all of our program, the standard trend. It will be implemented as soon as we receive the approvals that are necessary for us to be able to move forward, and it will be for those that choose to opt in, by doing nothing, or those who opt to have or to specify a rate, that automatic increase will be retroactive to January 1. And you are absolutely correct. That we only received funding for this investment for these direct care workers for six months in 2025 to 2026. I cannot predict what will happen in the next budget year, so we have this money now, and we wanted out the door as soon as we can. Great question Jeff.
>> Sorry Matt.
>> MATT SEELY: Go ahead.
>> The next question is from David Gates. Will there be any opportunities for direct care workers working in participant directed models to obtain subsidized health insurance?
>> JULIET MARSALA: HI David. Great question. So right now health insurance for direct care workers in participant self-directed would be available via penny. There is no funding in the office of long-term living to subsidize health insurance. There's no funding in DHS to subsidize health insurance so penny is the market exchange where direct care workers would be able to evaluate and look for health insurance coverage if they are not otherwise eligible for other insurance coverages through their spouse or Medicaid or what have you. That is the Pennsylvania market health insurance market exchange. Part of the investment of the budget was in the increase in wages was to provide some additional sort of spending power. For direct care workers so that burnouts they would be able to choose better health coverage through available avenues like penny. Good question.
>> This is Paula. One more question in the question box. This is from Mia Haney. The analysis of the cost difference between agency and participant directed services that was completed, how long ago was that completed ? Does it reflect current utilization rates, and could that analysis be shared?
>> JULIET MARSALA: Mia, the analysis between agency and participant directed services, I don't recall what the year is, I'm not referencing a recent analysis. But the oh gosh, maybe three or four years ago, so no it doesn't utilize current utilization rates. I would have to go back and look back on it. And see what can be shared. So, certainly I am willing to look into it. The analysis of the late increase to get to the 9.09% was done with current utilization within the fee for service programs. Trends and things of that nature. And certainly I will like to see if that can be shared as well. I'm sure it could be. I believe it could be so I certainly could share that.
>> MATT SEELY: Thank you Julia. I see there's one more question, but I think we will hold off.

We are kind of all-time. Is Jan Hail and Robin ready for their presentation?
>> JEN HALE: Jan is here.
>> ROBYN KOKUS: Robin is here as well.
>> MATT SEELY: Thank you both. He may proceed.
>> JEN HALE: Good morning everyone and I hope everyone is having a good start to the new year. I am going to go ahead and get us kicked off and then I will hand it over to Robin to review the proposed changes to the over waiver renewal and a traveler amendment in more detail. Just a high level, the over waiver is set to expire at the end of June issue, so we are prepared and have been preparing to submit the renewal application to the centers for Medicare and Medicaid services or CMS in March of this year. And just as a quick reminder, I think we do try and go over this at a high level in our meetings will go through waiver amendments and renewals, but CMS does require states to submit waiver renewals and amendments at least 90 days prior to the desired effective date. So that's why we are aiming for March. So our planning was really focused on the over waiver renewal since that will be expiring and we need to get that in, however, some of the proposed changes did warrant an amendment to the CHC waiver as well which Robin will review and outline. The proposed changes are minimal and do reflect suggestions from stakeholders over the past year. As well as general updates to the waiver application that was implemented by CMS. So as we've done in the past, we wanted to use this time during the LTSS subcommittee to review proposed changes and gather feedback and/or comments from stakeholders on those proposed changes. So with that, I will go ahead and turn it over to Robin. If you're ready to guide us through the proposed changes.
>> ROBYN KOKUS: Thank you, I am ready. Go to the next slide. So good morning everyone I am the director of the division of policy development and analysis with the office of long-term living girl policy, like Jen said, were focused on the over waiver renewal, and some of the changes we are proposing for the over waiver required some changes to CHC waiver, just to keep that to programs as consistent as possible especially when it comes to service definitions. So as Jen said, the renewal and the amendment will both be effective July 1, 2026. CMS requires states to renew their waivers every five years. And so the end of that five year period is fast approaching. The OBRA five year period was from July 1, 2021 and it will expire June 30 of 2026. Hence that July 1 effective date. Next slide. With every amendment and with every renewal, states are required to have a public comment period to allow stakeholders and the public and advocates and all of those great people to submit comments to the office of long-term living regarding our proposed changes. So we anticipate publishing a notice in the Pennsylvania bulletin in early 2026, so this could be now or in February. Announcing the availability of the over waiver renewal and the CHC Whaler reboot amendment, there is a 30 calendar day comment period after publication. Whatever date it is published, you have 30 days to submit comments to the office of long-term living. Either through regular mail or we do provide a resource account so you can email your comments into OLTL which is probably the most effective way to get the comments to us. Once the public notices are published in the Pennsylvania bulletin, the office of long-term living will send out a listserv message just to notify the public that the public comment period is there. And that the waivers are available for review and comment. We always encourage everyone to take a look at the renewal and amendment changes and if you have comments, please do submit them. We do use these comments to inform how we will create the renewal and amendment and informed any potential future changes that may be made to the waiver. Next slide please. So let's jump into it here. So teleservices, this is a change that will affect both OBRA and CHC, currently in the waivers, cognitive rehabilitation therapy services, counseling services, and nutritional consultation, can

be provided via teleservices, and we are going to add behavior therapy and benefits counseling services that may also be provided via teleservices. I'm excited for the change because it's like you do expand the services that can be provided via teleservices. Kind of keeping in lockstep with how our whole world is changing and more things are moving to tele-service delivery. That are both for OBRA and CHC. CMS actually issued revisions to the 1915 CHC waiver application and technical guide, so if you go online and look at the actual waiver application itself, there are several hundred page document that describes how OLTL and any other state agency would administer a waiver program. Everything from how to pay for and what the services are to how we keep a participant say, so it's a comprehensive document, it's a waiver application. CMS went through and revised at waiver application template and it's now known as version 3.7. Template revisions were made by CMS to the appendices B, C, D, I in the main module quality improvement sections of all appendices. I really want to present this to you because if you are someone who's familiar with the way the waiver application looks, once this amendment and renewal are made available, what CMS approves them and we make it available to the public, this way you are aware that it might look a little different because of an addition, some additions to the template itself. What other big changes was about the home and community-based settings role. In appendix C of the waiver application, CMS added checkboxes for the state to assure the settings meet the settings requirements. Also in appendix D these are different sections of the waiver application itself. CMS added sections for the state's to measure that the settings role is incorporated into service planning. And to a test there are safeguards in place to ensure public free service planning. Monitoring health and welfare, and settings role. And we also added some language that requires the service coordinator to include the settings requirements and service planning. Next slide please. So those are all of the changes that affect both OBRA and CHC, as you can see in CHC does changes are minimal now we will go forward and look at changes specific to the transit waiver. Some of these revisions tend to be more bulky because it's a renewal. So we are completely, we take a holistic look at the entire waiver and make the changes that we need to. And a lot of those changes had to be with removing and revising outdated language. Over a five period, as the program develops and evolves, and continues to meet the needs of participants, some changes do happen, so we want to get rid of the old and outdated language to make sure we present most current information possible to CMS and to the public. Again with the quality improvement strategy, we revised outdated language across all appendices. About the quality improvement strategy, monitoring process. What this means is that as like I said, as OLTL continues to evolve, a quality improvement strategy continually becomes more refined so we want to make sure the current quality improvement strategy is included. In the waiver itself. So CMS issued a final Luke called venturing access to Medicaid services. It was a final rule. It's known as the access rule. And that access will require states to implement a complaint system for fee-for-service waivers. We already have a complaint system in place. But we added some language to the waiver to comply with the requirements of the access rule. We also updated the timeframe to resolve a complaint from 45 to 60 calendar days. Due to the additional requirements of the access will. There are a couple extra hoops to work through in the access rule that are not in existing complaint process. So to allow our OLTL staff to do the investigation, and notification to the participant, we are adding the 15 days to allow them additional time to make sure they are compliant with the axis rule. In appendix K, we just added the beneficiary support services , we added BSS to the responsibility of independent broker, this is already in the CHC waiver so we are making her it's in the other waiver. Next slide. Again, just changes in OBRA, for service plan development, we aligned the service plan development timeline with the CHC waiver. What you

see if you are able to see, there is some language highlighted in yellow. I will read it out loud so everyone can be aware of what it says. The language highlighted in yellow is added to the waiver. Currently, the waiver says that SC schedule, service planning meetings at times and places that are convenient to the participant. And what was added was individual service plans must be developed and implemented no later than 15 business days from the date the comprehensive needs assessment or reassessment is completed. So we've added that service plans must be developed and implemented within 15 business days. Again, aligned with the CHC waiver. We also added language regarding the need for the service coordinator to reassess a participant due to a trigger event. So the SC is to reassess a participant if a trigger event were to occur or if the participant were to be without services to assist with daily living as indicated in the service plan for five consecutive scheduled days. Again, aligning language of the over labor to the CHC waiver for consistency across programs. Next slide. He also updated our estimates of participant direction of services. So, the waiter asked states to give numbers of participants that we hope will choose to be part of the participant directed model. And so we updated OLTL's goals for each waiver year, so the five-year period. For the unduplicated number of waiver participants expected to choose the participant directed model. This really is based on historic utilization. Numbers were revised downward. So for you instead of 279 participants that we hope will participate in participant direction, we revised it downward to 180. Based on historic utilization. This is not a top in any way. This is not a cap on the number of the people who may self-correct with the over waiver, this is just algal. If you exceed the numbers, that would be great and I think that would be the best case scenario. But we wanted to keep the numbers real estate based on historic utilization. So I'm happy to take any questions anyone has about the over waiver renewal or that CHC amendment. Matt, back to you.
>> MATT SEELY: Thank you. Let me acknowledge first George Fernandez has joined the meeting. And I see we have a question.
>> The hand raised is from Lloyd Wertz.
>> MATT SEELY: Please Lloyd.
>> LLOYD WERTZ: My question, for the previous speaker, I got here late sorry about that. I heard a reference to stakeholder, but not to findings but I was wondering if there was timing frame established for those presentations? You can answer this later, for now, your pick, I'm glad to be here and sorry I was late.
>> MATT SEELY: Thank you Lloyd.
>> This is Juliet.
>> JULIET MARSALA: They should be rolling out this calendar year, I don't have specifics for you. I mean certainly all that it for the subcommittee meetings are out and posted. But for additional stakeholder engagements, they anticipated that information should be coming soon but I don't have specifics at the moment.
>> LLOYD WERTZ: Thank you.
>> MATT SEELY: Thanks Lloyd. Paula, do we have questions, not reference you Lloyd, we have questions about this presentation? Numeric I see that Italia Gomez has her hand raised after the presentation. Natalia you are free to ask your question.
>> MATT SEELY: That Italia can you hear me?
>> Yes I can, can you hear me? I don't know if it's a question or statement, but listening to the presentation, it sounds like these may be aligned to changes to align the programs with each other. I guess I'm expressing a concern as a participant. Because of the CHC side when they do the final service of the development of the final service, is a reassessment for trigger events, CHC is falling quite behind doing those things. So I am opening that this alignment is for the

better. That those in CHC waivers don't fall behind even though were in the same boat.
>> MATT SEELY:Jen or Robin do you want to respond.
>> JEN HALE: Thank you for the comment I appreciate your insight. We think these changes to the OBRA waiver, at a non-general Julie I want to add anything. But appreciate your comment.
>> JEN HALE: Thanks this is Jen. The intent is to align to ensure service coordinators are taking a look at participants when there's a trigger event and ensure they meet the timing. So play again as Robin said, there won't be delays. It's really a change to ensure health and safety and services are being provided timely for participants in the OBRA waiver and certainly Juliet if you have anything additional, please feel free.
>> JULIET MARSALA:I do not. Thank you.
>> I have two questions imagine that if you want to continue with those! Yes please. The question is, does the CHC renewal include the start of the additional to MCO's for the CHC waiver beginning 7/1/26. ? I can take that. It's an amendment to the CHC waiver service.
>> That CHC RFA, no activity currently going on with regards to the RFA because it is a stable stop I don't think the addition to MCO's are no edition of Anzio would be material to the CHC waiver amendment which is an adjustment to the waiver because you know the CHC waiver was renewed in previous years. Certainly if any additional changes needed to occur we would work towards an additional amendment. Anything you want to add?
>> JEN HALE: No Juliet, you covered it. Thank you.
>> The next question we have is from Jeff Eiseman. How many individuals in PA total are on OBRA waiver currently ? Hang on. Okay. His recall is that it has been in the 6 to 700 range. And also how many individuals in the CHC waiver currently?
>> JULIET MARSALA: This is Juliet, Jeff, based on the latest OLTL data – which has been published, there were 690 individuals in the OBRA waiver. So this would be November 2025 numbers as a close of November 25, 690 individuals in the OBRA waiver. 396,112 individuals enrolled in CHC in total. Of those 150,288 are receiving letter HCDS and 47 and 4742 are enrolled in long-term care which is typically nursing facility services.
>> MATT SEELY: Any other questions, Paula?
>> Hi Matt, this is Paula. No other questions.
>> MATT SEELY: Can I make a point here. Remember the IT people running the meeting. I have a comment in that chat and I don't know if the people listening are feeling the same way, just as I question, Julie and Matt are allowed all my speakers, and every other commenter is extremely quiet, oh sorry, Anna wore height, and using a different computer today so not sure if it's on my end what is happening for everyone else. I've asked at least two or three people to speak up so that's definitely happening to me as well. That said, I believe we are at our 10-minute break. Or it will be 15 minutes. We will return at 11:30 a.m.. If everyone is okay with that and we will have our enrollment in redetermination data request presentation. Someone tell them, do as you do. In an It's been a while since we provided this data so I want to start the new year off with the current information that we have. Next slide please. The next few slides on our data on records or obligations in process and how long they are at a current status within the process. The status is listed on the left and the description is all the way to the right. In review of the data provided. Each status has been steady with what has been historically anticipated for each of the statuses. So I will not read each individual slide . I will give you a moment to review the data and we can move on to the next slide.
I think we are good to move to slide 3, please. So for this, these specific statuses, they are related to functional eligibility determination. And the receipt of both deposition certification and the completion of the FDD. As historically known the receipt of the certification is often the

longest time period a application is in a status, but the average days have maintained and remain steady and as you see also the average days for a FED to be completed has maintained within expected time frames. For the receipt of those assessments. Next slide please.
The statuses for on the slide as well, they have been maintained and remain what they historically have been over time. Next slide please. Our status is for these have also maintained what historically has been seen. I do want to go out the 28 in the financial denial status for July 2025. That was an erroneous data issue. We have corrected that so that status would have actually been maintained on 0. It was an interface issue for that for that date that the data was pulled. I want to make sure that was clarified. So this side gets into the overall application time frames for all applications that were open and completed within each quarter. We have maintained a 99% compliance of completing applications within the 90 day time frame. Since quarter one at 2024. Through quarter three of 2025 . And our average days of completion have been maintained around 35 days. And this is the same presentation of applications within the quarter that have been completed . This slide though represents all applicants that were over the age of 60. It is broken down for that population . Next slide please. This is the same data for the population broken down for our applicants under the age of 60 years of age. Next slide please. The next few slides are representing our breakdown , the closure reasons. For applications. It is sorted by highest to lowest. So the closure reason is listed on the left. And the description of the closure is on the right. Beginning with the number of individuals that had a close obligation with the outcome of it being enrolled also again, the next highest is failure to provide information to the County assistance office. Wanted to call out though in no circumstances that IEB does reach out to individuals and offers them assistance in gathering information and reopens an application to get them on to the next step if they are able to gather and get the information to the County assistance office. They are proactive in that outreach when that occurs. Next slide please. And I think we are good to go to the next slide. And that completes all of the reasons that are collected by the IEB for our closed applications. Next slide please. So the next is and I don't know whether you prefer if there are any questions on the actual applications at this time or I can move on to the next slides, our information on appeals that have been received for applicants that are determined ineligible due to functional eligibility. Next slide. And the information identifies the status of the appeal. Based on the month that the appeal was received. As you can see through the 2025 year the majority of appeals were related to individuals that were due to a medical director review. And that occurs when if the FED outcome is different than the outcome on the physician certification , the IEB submits the information to a medical director to review and make a final determination. If additional information is received, the IEB does work with us to review that and as you can see the higher number of appeals that are withdrawn anecdotally although we don't collect all the outcomes or have that data available from hearing and appeals but anecdotally, often times the outcome is a new assessment for the applicant. Next slide please.
>> MATT SEELY: This is Matt. I'm afraid I'm going to have to be snarky. I am just wondering if the transcriptionist has gotten all the , hold on. I apologize. So much for screening goals. I just wonder if the transcriptionist has gone all the details of your presentation here. For the record that everyone is trying to follow along. Do you understand, what I am asking.
>> Yes there it is.
>> MATT SEELY:I think you are assuming you are reading this along with you when in fact, I assume there are some people on the call that have no idea what's on the screen.
>> I can do that, would you like me to start from the beginning.
>> MATT SEELY:I think we should. If you could give us , I don't want to say we've wasted time

but I think we do need to need to rewind a little but give us the 50,000 point of view with the highlights. In the interest of time.
>> Matt and Amy, if I could hop in with one interjection.
>> MATT SEELY: Please go ahead.
>> It is fine. Amy, when you go back to do the 64,000 foot view, if you just note the slide number then anyone going back into the transcription and following along afterwards, if they miss the meeting with the slide deck can reference the slide while you're talking I think that will help.
>> AMY HIGH: Absolutely. So going back to our enrollment data slides. Beginning at slide 2 which is our data for the number or the average number of days in an application in status. And this data is for the average days from the month of June 2025 through November 2025. And the statuses that each application is in they have the average days have been consistent from what we have known historically. And, the data I don't know if you want me to read all of them, but, I can if that helps. Ready for assessment which is when the IEB has received a referral . And is reaching out to the individual to schedule a visit. The average has been inconsistent with the low being 12 during that timeframe and a high being 20. The average time an individual or an application has been in the status of the in-home visit has been scheduled has remained an average of 6 to 7 days. And that is the timeframe in individual one application has been in the status of a scheduled visit to when they visit actually occurred. Assessment in process, is the status of an in-home visit being completed. And the IEB reviews the information to make sure everything is accurate for the next steps and that has maintained an average days of 1 to 3 days being the high. The next status is medical assistance application review. And this is a status where the IEB is waiting for the medical assistance application to be received or entered into compass. Moving on to slide 3. Again this is for our statuses, these are our functional eligibility determination. Where the physician certification and the FED must be received to move the application on to the next step. The average days have also been consistent. Noting that the longest time most applications are in a status is when a physician certification is still pending. And the specific status averages around 35 days. The status for FED being received by aging well those diaphragms remain consistent with between 10 and 12 days. Next slide please. The statuses represented on slide number four The statuses represented on slide number 44 application review is when an application is pending review. By our medical director , and those average time frames have been consistent between one and a high of three days. OLTL ready which is information , and application is being reviewed by OLTL for program eligibility . This is specific to our OBRA act 150 applications. And these time frames are often high due to the low number of applications if one needs additional review or consultation internally, it increases the timeframe. But this has also been consistent with historical data. With a high of 30 days and an average low of 21. Ready transition is our applications to the individual is residing or receiving services in a nursing facility at the time they are applying for home and community-based services and those applications are often open and allowed to be open over the required 90 day time frame to allow coordination and transition between the different entities for services to be implemented upon discharge. And the last status on the slide is approved. Which is representing applications that have been found functionally eligible for waiver but are waiting financial eligibility by the County assistance office. And I think we are ready for slide 5. And the remaining statuses represented on this slide are applications where the 1768 denial for the individual was found functionally eligible, in the status that IEB issues a notice to the applicant noting why they were denied. Before closing the application. Financial approval again , the CAO has approved them and the IEB sends information to the participant letting them know of the enrollment as well as notifying the managed care organization or the service

coordinator of the enrollment . The service coordinator pending applications where the IEB is waiting for confirmation from the selected service coordinator that they accepted the case. And then financial denial which I noted earlier the anomaly of the 28 that has been corrected , and was an interface , an erroneous interface issue for that specific day. And then financial approval mismatch is where the County assistance office may have entered into correct waiver code, and the IEB is getting up corrected to move them forward. Slide 6, please. Slide 6 highlights all applications that have been in process for each quarter. And we are exhibiting data from quarter one 2024 through quarter three 2025. The compliance for the IEB has been maintained at 99%. For applications to be closed within a 90 day time frame. And the average day for completion of an application has been maintained at around 35 days. Next slide please. This represents all the applications that were open and completed for our applications over the age of 60 during the same timeframe beginning in quarter one 2024 through quarter three 2025. Compliance for individuals over 60 is also 99% for applications being completed within a 90 day timeframe and the average date for completion has also been around 35 with a high of 38 in quarter three of 2024. Next slide please. And this is our application and process. And completed for our applicant's under the age of 60 from quarter one 2024 through quarter three 2025. This population also had a 99% compliance of the IEB completing application within the 90 days. Added average date of an application being open being 35 days. Next slide please. This letter represents our closure reasons. For our applications. Beginning on slide nine, it is sorted by highest to lowest foreclosure reasons. Enrolled applicants for the quarter 3, 2025 was 8152. The next highest reason foreclosure at 7812 was failure to provide information to the County assistance office. Again, wanting to highlight that the IEB is proactive when an application is closed for this reason, they reach out to the applicant and offer assistance to gather the information or assist the individual and reopen the application if they so choose. Other reasons foreclosure. This slide is unable to reach , again, IEB's unable to reach the applicant they are required to reach out to an individual three times on three different days and they often it is their practice to do additional outreach one fourth and fifth time before closing application. This slide also , incomplete applications, that represents applications where the IEB may not have for example received a physician certification if that information is not received by day 86 of the application, the IEB will close the application with notice to the applicant. And if that information then is received they will open a new application right where they left off and move it forward. We also have on this slide individuals that are found functionally or clinically ineligible . Voluntary withdraws for applications. Next slide please. This slide, other reasons include individuals that are closed due to being determined financially ineligible by the County assistance office for individuals that are financially ineligible. If they are under the age of 60 IEB will review them for act 150. If the individual chooses to be considered for act 150, and if they are over 60, they will refer them to their local agency on agency – – on aging for consideration of the options program. Other reasons on this slide, if the application is not discharged within 180 days of that application being open the IEB and again these are individuals that are in a nursing facility at the time of application. The IEB will close that application at 180 days, but will reopen any obligation to continue the process if the individual is still working on finalizing their discharge. Next slide please. This slide 11 is the final reasons foreclosures. And this includes applications where the IEB did not receive medical assistance applications for an individual that had started with an in-home visit. And also individuals that had insufficient information where they received a referral and they didn't have enough information to be able to move forward with an application. I think we are okay to move on to slide number 12. Which again gets back into our FED appeals and again the data that I will be showing in the next few slides is appeal

information for individuals that were found functionally ineligible for waiver services. Specifically individuals determined N FI. Next slide please. Slide 13 , it represents the data and the appeal status, my apologies, for the months of January through May. 2025. And the status that those appeals are in. For these first five months. The appeals were received specifically for individuals found , nursing facility ineligible for a medical director review. And the status that they are currently in. The highest status is appeal withdrawn. Although, as stated prior, the detail from the outcome anecdotally often the appeals that are withdrawn results in a new assessment. For the other highest status for these months are appeals settled. And or appeal dismissed. Next slide please. Slide 14 is similar data. Or again, showing the status of the appeals for the month of June through September. Of 2025. Wanting to note in June there was an appeal also received for an individual that amplitudes an application had both the Fed and physician certification MFI so as individuals to receive a denial notice and a right to appeal as the same as the medical director Jamal, had the status is. Again the highest status is the appeal withdrawn or dismissed. For these appeals as well. And moving on to slide 15. It should give us the status for October and November. That data for when the slides were bold together, the data for quarter three or December is not yet available. So again for October and November, we have appeals for individuals that were denied due to a medical director review, and at this point, a majority of those are in the initiated stage and are awaiting the next steps from the hearing and appeals.
>> MATT SEELY: Amy, can I interject real quick. I'm looking at the agenda. And Tyrone and Erin going to have presentations as well?
>> AMY HIGH:I believe Tyrone has a few slides but I believe I have the majority of information.
>> MATT SEELY: Because we have until 1215. So it is all trivial or trivial or however many presented him a R all three of you going to be within the last 12 minutes? I'm trying to manage time .
>> Matt, this is Paula.
>> MATT SEELY: Go ahead.
>> I will give you insight here. So Tyrone, slides are within the presentation here with Amy. And errands unfortunately will not be presenting this month. We are slating her for next month now.
>> MATT SEELY: That is fine.
>> Tyrone only has two slide so we should get through them.
>> MATT SEELY: Fair enough. Go ahead Amy.
>> AMY HIGH: Thank you. And I believe I am wrapping up your shortly. Next slide, number 16 please. And for reference, slide 16, it just gives a description of each status. Of the appeals. That were stated in the previous slide. Next slide please.
This slide is , it represents data on the reasons individuals change managed-care plans during the month of November. And the highest reason an individual changed plans is due to a provider no longer working with the managed care organization which was reported. And it lists each reason just for time, the top reasons were what I just mentioned with the provider no longer working with the MCO, or the individual is dissatisfied with the medical MCO status. They were transferred from an auto assigned managed care organization , they were dissatisfied with service coordinator. They prefer a nonparticipating doctor or hospital. They would not give a reason. Or they were dissatisfied with range or length of services being too limited. So those were the top reasons. And there are additional reasons also listed on slide 18. I think we are good to move on to the next slide, and I think that might end my presentation and I will pass it on to Tyrone. Thank you.
>> MATT SEELY: Do we have Tyrone?

>> He has his hand raised. He may need assistance on muting.
>> MATT SEELY: If we can't get him on muted I can do them. This is Randy.
>> Tyrone you are on muted from our end. If you're having difficulty, we can have Randy do your slide.
>> I will jump in. Tyrone, is that you?
>> I will jump in and do the slides. This is Randy Nolan. We've been looking a lot at the and FI process when participants have new RTI done. We've been monitoring how many of them are coming back as being and FI. We are reviewing all of these cases and going through them in the making decisions through the medical director review process. At first slide here shows the 2025 CHC waiver participant assessed and FI. And for the first quarter of 2025 January through March, 687 individuals. CHW had 201 (off mic) for a total of 901 individuals. For the second quarter which is April through June, Amera health at 533. Which was a decrease of 150. Pennsylvania health and wellness have 173. And UPMC had less than 10. So we went from 901 data 712 as a total. For the latest data we have another quarter July through September, Amera health at 538 pH W at 219. And again less than 10. For a total of 766. We have worked extensively with the MCO to reduce the numbers and to continue to monitor them. They put a number of processes in place. So they are catching these that may be MFI before their entered into the state system. So we continue to work with them on the progress of this. We are seeing anecdotally for the end of the fourth quarter we are seeing a reduction in these cases especially from Amera healthcare. So will put those numbers out the next time we present. All right on Exide . Kind of just put the in a graphic look here. I MCO. By quarter comparison. So it should stay look at in a bar chart format we are seeing a downward trend in CHC based services participants becoming NFI. And we seen a 35% reduction over the year over three quarters in the cases coming back NFI. So we are continuing to monitor them. Like I said we've created a pretty extensive internal process for anyone coming through as NFI through the medical director review process for getting a lot of documentation and service coordinator notes and other documentation to review these cases. For the most part we are getting the information we need so were making strides in improving this so in a inappropriately disrupting anyone service. The other thing we've done with this so that we know is probably not on the slides as we have a training that OLTL did with our training coordinator . It is a refresher training on 9.2 that we are requiring all service coordinators no service coordinating supervisors and all FED assessors, AAA assessors to redo this training at the end of the month. So we are providing some refresher training out there. We will also be providing the same type of training in the next few months probably the summer as we move to the new version 10. We will be providing some of the same training out there so it allows the knowledge that all assessors and service coordinators are on the same page as we move forward with these assessments. So a lot of work being done internally, a lot of work with the MCO to improve the process so we are ensuring we have good valid assessments being completed. I think, is there another slide order is that it? So if you have any questions about this about Amy's presentation, we can take them now if you want to wait until the Q&A period, we can move forward with that.
>> This is Monica from the brain injury Association of Pennsylvania thank you for the data. I have a few questions/comments about , I'm sorry, did someone interrupt? I'm okay to ask this question .
>> You ahead.
>> I was struck by the very high number of people whose applications are close because they don't provide the financial information to the County assistance office in a timely way. I'm not surprised but struck by it. We see this all the time, for people cognitive impairments, that such a

challenging thing to accomplish. It requires gathering a lot of information going back years. For people with cognitive impairments like executive impairment, it can be a task not possible for them to do without direct assistance. So I guess my question is, I'm glad to hear the IEB reaches out when this is an obvious problem occurring. But is there any direct assistance to the applicants who really just can't do this on their own?
>> This is Randy. There are a number of names we try to provide assistance in the program when they need to revalidate. One, if they are already in OLTL – – CHC, the responsibility the service coordinator to assist the person ensuring the application information is submitted for revalidation. And you know beginning in January 2025 we implemented a new service through the IEB support services, through the set IEB to assist with this very thing. The system is revalidation, systemic getting information they need, assist them if they have issues with the MCO, it's a wide-ranging set of services IEB provides. We have a number of avenues were trying to assist people with getting this type of paperwork done so they are not being taken off the system because of paperwork.
>> Thanks Randy. They tell me the name of the assistance program, did you name the program and I did not catch it.
>> Beneficiary support service.
>> Thank you. This issue occurs not just in the revalidation but in the early application process where people never even get in the door so they would have service coordinator, is that available to people who are in the early application process as well?
>> They first come onto the program and needed assistance with it the IEB has a mechanism in place to provide assistance oh yes.
>> So we should tell people to request that.
>> Yes. If they need assistance when they go through the application process they should be discussing that with the workers from the IEB that assist them that they say to them we need support we need help getting your financial documents, the IEB will help case manage them to help them.
>> Thank you. The one thank you Randy. Let me just say this real quick. I hope everyone will therewith is a little bit as we get RC leg so to speak. And I hope I didn't derail any too much by them. I want to make sure everybody's able to participate. With that, questions, I think we will give everybody two minutes of questions. And going forward if anyone has a really detailed question, can you hold those for the afternoon .the afternoon, but the second round of questions going forward. The first round we will try and keep relevant to that presentation. So right now, we would be telling the questions that have to do with this presentation for the time being , the enrollment and redetermination so I did see these questions appear, can you please choose one.
>> Hi Matt we have three hands raised by members, and I have three questions and then chat and I'm sorry which did you want me to address?
>> MATT SEELY: Let’s start with members. And I believe I saw Lloyd , he said something first so let's start with Lloyd.
>> LLOYD WERTZ: Thank you very much, a quick observation, issues with County assistance office, having occurred at such a large high level with those offices, it's not going to get better all we are hearing about is distress for an understaffed system. In moving forward further stress due to these ridiculous having to reapply every six months requirements then placed upon us through the horrible resolution one passed at the federal level. I wonder if there's a way to try and get better assistance directed specifically to people applying for this type of Medicaid coverage ? Just wondering. Thanks.

>> We do understand we have issues going for because of the new requirements to do revalidation's every six months on a certain part of the population. We will not have a big direct impact on LTS population CHC because they will be under the requirement every six months but we know that it will be an impact on the overall system. Because of that. There's been a lot of conversations between the apartment. Of how we will be able to do this with dominance, there's a lot of stuff going on, to address these issues. There's a lot of work knowing we have a section on work being done so we recognize that. – –.
>> LLOYD WERTZ: Thank you. Spoon go ahead Paula.
>> Can you hear me. The next member with a question is Kathy.
>> Thanks Polly. And thanks Amy and Randy for the presentation.
>> KATHY CUBIT:,I want to add a point to add to what Monica Emily had mentioned. It also make a recommendation to the extent possible that OLTL can work with oh I am to move more to ask part day or change in policies where DHS can get needed information directly from financial institutions. In addition to what's already been mentioned, caregivers particularly those helping those with cognitive impairment great challenges accessing this information as banks and other financial institutions increase protocols and policies to help fight financial exploitation. I just think that's another area that's often overlooked in this discussion. I also want to quickly ask regarding the NFI in slides 20 and 21, it seems to be why disparities among the three MCO plans, and I think it would be helpful to see a total number of how many new and RI assessments are doing and how that compares to the an FCE at the NFI rates overall and I don't know if slides can be broken out by plan as well. Because it seems like there's a big discrepancy among the plants. Thank you.
>> We can certainly provide the data on the number of NRI done so you have an idea that all right we did 30,000 NRI over the year and this is how many came back as NFI. We can start by providing that information we can certainly touch on site 21 . That something Tyrone and I can discuss.
>> This is Julio. Sorry Kathy. This is Juliet. I want to address some good points you made Kathy. About evaluating and streamlining and having the opportunity to have data feeds from financial institutions. I did want to note that sort of changes that involve sort of automatic data access and financial fees from financial institutions is a huge complex process and system. If we thought aligning within just meditate was challenging, when you start aligning across financial petition regulations and Medicaid regulations, gets much more complex. I want to point out, it's a question that has been asked. It's a topic that has come up. In a couple of hearings with the general assembly. Because sort of in order to move the ball forward, it does not just sit within DHS. So necessarily something that can just be changing the policy. Their statutory consideration, there may need to be changes in legislation. It could require a lot of education with representatives. So I just want to kind of share a little bit about that context because I know there's a lot of value in that and I just don't want folks to be frustrated or feeling like DHS is not doing anything. It's just a massive complex question and path forward.
>> This is Kathy. I hope I did not imply , I know this is very complex just for the sake of time I just think continue moving in that direction is going to be a growing importance looking at that number and again the changes that are happening in the banking and financial institutions side that made it hard for people to get that information.
>> Had them take it that way at all I know you are a deep expert in the subject and other folks who have joined may not be as aware of the complexity of the issue, that's all.
>> Hi Matt this is Paul the next member question we have comes from Natalie , Natalia Gomez, you are on muted.

>> Thank you so much I appreciate seeing this and appreciate the hard work that you are all doing. I know it's very complex specially when there's a lot of policies and regulations in place. I have a couple of questions going to the IEB enrollment data. To me being a participant and also someone who assists individuals from the beginning of the application process, it always astonishes me that everyone knows and recognizes these are cost-containment programs yet based on the experience I don't see the cost-containment . The point and initiation portions, there's a lot of money being wasted. For instance, as I saw the IEB enrollment data, the PA 600, I'm confused with what is stated in no slides because I want to know who submits and who completes that PA 600? Because at one point it says the IEB is waiting to receive the application to enter into compass. Receive it from whom? And enter into compass after the participant or the applicant has submitted because there's a lot of confusion out here on the ground in that aspect. Also the physician certification is one of the longest parts that sustain these applications from moving forward. So my question is, who says the PCP form to the PCP is at the IEB is it the applicant? Who does it to move this a little further? That's in the IED part of the enrollment data. He also said the IEB is proactive in helping participants and applicants with this submission, for instance hearing Mr. Nolan state to Kathy or to Roy there are several things in places to assist participants with the beneficiary support services, does that include the visit to get those documents because I can tell you on the ground, that's not a reality. They do come but the pressure and the responsibility for getting these documents is still based on the participant who are unable to obtain them. So can clarification be made on that because I believe there's double repetition work being done. When it comes to the application form. And that's with the IEB enrollment. With regards to the appeal and the NFI numbers I was taken back. I would like to know, to all the MCO's use the same tools to do their assessment and if they do so then why is there such a discrepancy in numbers and a difference in the numbers with the MCO and their health being the highest even though there is a downturn.
>> I will answer your last question first and then yes they all use the NRI tool, the assessment will dictated for the MCO to be used by the department. So the NRI is the same. Some of the disparities you see , there's been concern about reliability so to make sure they are all being trained to use the tool in the same format some of the disparity is by the fact that America health is a much larger population mph W does. And you MPC. So there's been some questions about training. That's why we've done this training that we are now requiring . So we close some of these gaps that are occurring because people not being trained appropriately. The other part is trying to keep up on the training, is a fairly turnover service coordinators in this program. So that causes issues such will be addressed some of the things so we can get these numbers closer to what they are between the MCO. And I'll let Amy chime in on some of the IEB staff mean the IEB does the initial visit and it during the visit they start the process of getting the application done, completing the PA's exam, the IEB can assist with that, the family can do it no long person that can complete this information. As somebody is telling them they desisted to pay work in you telling me that IV is not assisting them, I'd like to know specific cases when that's occurring so we can reach out to the IBM correct that and have those discussions on what assistance is supposed to be brought but even after the initial and home visit summary calls the IEB a week later and says I just can't find my insurance documents are identified my bank documents, can you help me get this done, the IEB should be assisting them in providing them some case management to assist them in getting those documents. So it is part of the whole process. Now Amy, I don't know if you want to anything to that or not ?
>> AMY HIGH: Thank you Randy. The other thing I would add all the questions with different closure reasons specifically the one where the IEB did not receive that PA 600, I just wanted to

note that the application process is part is event driven so that IEB does take the lead of the applicant and can receive referrals and applications numerous ways. One of those being when the individual completes the compass application online. And if they don't receive the compass application online, and if the individual doesn't want to complete the PA 600 or decides not to sign it and move forward, please application open and follows up them for up to 30 days and that's when that application is closed. That's the clarification for that specific status. As for the physician certification, the IEB sends the physician certification request directly to the physician, identified by the applicant . The position certification form is also provided directly to the applicant at the end home visit if that is their preference to get it completed on their own. In the IEB does follow-up multiple times with the physician to get that completed but it is always been the challenge at times to get those completed with a quick turnaround. So a little bit more detail on those questions.
>> Unfortunately we have a high percentage of physicians who do not send the forms back . We do a lot of follow up with them trying to get those forms in. But as you know a lot of times doctors offices just don't want to fill out forms ordered something put on a pile done once per month. So we have continuing problems trying to get the forms back in.
>> MATT SEELY: Paul, before you move on I would like to say one thing. That was a detailed question and a good question. I'm not sure yet, I can't really say if all aspects of your question were answered. So whoever is running the meeting, you put my email address in the RA email address in the chat box, I really care if I get those emails or not. If anyone feels the questions were not adequately responded to orders follow-up, please feel free to respond to myself or the RA. And also in that regard the two minute rule I kind of put out there a minute ago, is only going to apply to people who are not panelists. Anyone is a penance as is much as you would like, feel free. The two minutes I like to ask anyone from OLTL to be in charge of that. Please be in charge of that. With that being said please Paul give us that expression.
>> Hi Matt, the next question is going to come from Rego Sheppard is the ultimate for payable walls. Rego you are on muted.
>> Thank you. So I think this is a closely related question. But just trying to understand a little more of the mechanics of the IEB operations. So just for context, I work for legal services together . We are often involved when a participant is applying and receives a denial notice orders doing renewal receives a denial. So I guess I am just seeking some clarification on what stage BSS would be involved. It sounds like maybe when someone requests the assistance that everything sort of stays open for 30 days and there are no notices issued. But I would just like to understand a little bit more if you could provide that context.
>> That BSS services can occur anytime a participant as a question or potential participant as a question. They can be triggered on the initial phone call or triggered at the end of visit are triggered when summits on the program for a year or two years if they have issues. So they can be triggered at any time throughout the time a person is applying for or on the program. One of the things, I noticed in BSS being fairly new, we do some administrative trainings and outreach from the IEB to various groups out there. But certainly if you feel it would be beneficial for you and your fellow staff down at CLS MPH LP if you want, certainly if you send me an email I can set up a meeting with you and the IEB to walk through exactly what they do with beneficiary support services so that you have that information and can potentially contact information when you have questions so we can certainly do that. But it is a process that can occur anytime.
>> Okay. That sounds helpful Randy. Thanks for offering that. I'm specifically sort of thinking we do duplicative work here? It's a little unclear to me whether or not BSS would do appeals. It sounds like that's not their function.

>> We will not do appeals better some calls in to the IEB and says well you know what to appeal the decision my MCL made but I want to talk to them about it, can you help me file the appeal they could assist with that.
>> Okay. Okay. Thank you.
>> MATT SEELY:Is at all the questions Paula in regard to this presentation? Go ahead Carol. I see.
>> CLE I want to apologize for my ignorance, but I would like to make a comment. I don't know who I would make it to. Whether I make it to Julia , Julia, Matt,
>> MATT SEELY: Julia I will need an assist to. The heater going on in the background so it's hard for me to understand. Julia, can you assist her?
>> JULIET MARSALA: Certainly. So Carol, can you repeat for me that question.
>> CAROL MARIFISI:,I apologize Juliet, for my ignorance. Maybe it's because my availability I went – – but I feel like a lot of the presenters presentations were excellent. And well-prepared. I think there are people like me who doesn't work in the service delivery. There would be contacts because I feel like there are always acronyms and things in their to be personal and I should read more of because I get lost in what were talking about.
>> JULIET MARSALA: That is a comment well taken Carol and that is something that I can bring back with my team. And we can do a couple of things but for everyone's benefit, the comment certainly very appropriate. Is that a lot of these presentations that go down into the weeds of our programs. You know, are often times not easy to follow. We may be using a lot of acronyms in our presentations, and it would be really helpful for us to keep in mind that we need to ensure we always have the broader context explained as to the why and the importance of what were presenting and how it fits into the system, and how it impacts every member of the LTSS subcommittee in particular the participants who receive services. There was a request for assistance to help ensure that LTSS subcommittee members were well-prepared and kind of understand the context of what were talking about the acronyms and asked for us to further support that. Is that about right Carol?
>> Thank you very much.
>> JULIET MARSALA: We will bring that internal. And make a point there's always room for improvement and we will seek to improve the throughout this calendar year. Because it's really important for you to be fully engaged and understanding and it's very complex. Like I also am still learning things. Even after being in the field for over 20 years so I get it 100%.
>> MATT SEELY: If I get adding Carol, I see Paula put both my email address and the RA email address , your point is very well taken. If I did not understand what you're saying but I do take your point. Please if anyone on this call is any kind of concern like that, you have my email address in there. And I would like to address everyone's concerns. And I saw , I can only see people that talk when the little green thing up there goes. I saw a number of people that wanted to make points as well so please go ahead. What if not we will go to the next question.
>> Hi Matt. This is Paula. I have three questions in that chat and I see Brenda raised her hand.
>> MATT SEELY: Any of them are from members, start with those.
>> No, not from members.
>> MATT SEELY: Go ahead.
>> Brian Johnson has a question and that chat. His question, is does appeals settle explicitly name the decision was overturned or are there other reasons that go into a settled status?
>> I don't know if Amy still on or not because she was going to leave at 12:30 p.m.
>> I am still here .
>> Amy if you get answer the question, if not we get answered after the meeting.

>> AMY HIGH: Let me take that one back if that's okay.
>> I have another question here this is Paulo. From Jeff Eiseman. Question is what if any impacts to IEB and FDD data are in effect or anticipated related to federal HR one? Medicaid changes for PA? Are there or will there be any additional training related to these changes for IEB or other key staff and volunteer?
>> As we evaluate the changes coming through because of the bill, if we certainly need to change things, educates have whether IEB or aging well, whether it's the NCOs, will certainly provide the education and upgraded knowledge to them so we are meeting the requirements of whatever's coming out of the big beautiful bill. HR one, it will certainly take a look at . So yeah as things come into fruition and reality we will certainly address the with all of our vendors to make sure we are good.
>> If I can just one moment, I'd like to let the record reflect that Randy acknowledged the big beautiful bill.
>> Yeah I know. Don't let the record reflect that.
>> That's funny.
>> This is Paula. Another question the Magi, and I apologize if I mispronounce your name. I think this is for Robin and Jen. Do you know whether CHC insurance conference contracts for agencies are supposed to open the share, agency is operated for two years but I've only received two act 150 participants in many newer agencies are experiencing similar challenges with referrals and context.
>> Paula, I can answer them all. This is a situation will be Habré matters out there and you agencies other that are trying to enroll with one of the three or all three of the see HCM as part of their provider network. Again, as we discussed multiple times, L LTL is not direct the NCO who they have to have in their network. Our direction to the NCOs is they have to have inadequate network to meet the needs of participants. We monitor that number, we do a lot of work for the monitoring team and for Mike Wilkinson's work with his teams, in regards to monitoring the networks out there. Across the board whether it's physical health providers. There's a lot of work going into injuring that we have adequate networks – – ensuring that we have adequate networks out there. There are thousands of older agencies across the state. Even down in the Philadelphia area is probably close to 1500 agencies that serve that area down there. It is not feasible for the MCO to contract with every agency that's out there. They have to look at the efficiency of their network. If you look at the quality of their network. They do a lot of work when they take a look at their network and evaluate what they need in the network. There always open to document agencies that they provide some type of services to a specialized population whether it's cultural or language. Population 70 take a look at them. They take applications and keep them on status so if they are making changes to their network they can do that. But the role of the MCO is to ensure they have enough providers to provide services other providing an efficient program. So I don't know , I'm sure that conversations I don't know that there networks that will be open. Once in a while have counties that they need additional home health agencies in. But I do know about there being a widespread opening over the next couple of years.
>>.
>> JULIET MARSALA: This is Juliet if I can also ask in response to the question, if my team can put into the link and send out with the materials for this meeting, the latest OLTL data brief data dashboard. So that folks can really take a look at the numbers to Randy's point of there being close to 1500 home care agencies in the Philadelphia area alone. Just to contrast that you'd indicated you received two act 150 participants which is great. There are only 1100 act 150

participants in the Commonwealth. And so just to kind of put that in perspective. We have more home care agencies Avenue participants we served with the act 150 program. So I think that data might be helpful for current and potential home care agencies that are seeking to serve Alberta residents. I encourage you to look at the data.
>> Hi Matt, this is Paula, we have one hand raise, it's Brenda Adair. Brenda you are on muted.
>> Can everyone hear me?
>> Yes Brenda.
>> I apologize, I'm dealing with a wicked case of bronchitis so I will try to be as easily understood as possible. This is the first time ever I have, as an individual participant with a question about my services to this group. And I'm hoping I can get a follow-up call from either Randy or Juliet. I'm in act 150 participant, and I have been for 30 years. I've not had a significant change to my income and the last two years. But I've been asked to provide a bunch of information to the county office that I never have before. And I went just like Tuesday to someone about why this is occurring, I understand it's part of a redetermination but how to handle this specifically. Because I have some individual concerns. And I don't seem to have the right person to speak to about that because I'm not getting all the mail notices I need in order to participate fully in this process.
>> This is Randy. If you shoot me an email I can work with you and you follow-up there.
>> Okay Randy, I'll do that this afternoon. Thank you.
>> Okay.
>> MATT SEELY: I'll say this for the record, as we say things for the record, I consider Brenda to be a very knowledgeable person about these matters. And it Brenda is having trouble navigating that, that is very telling to me. Paula, any other questions?
>> Hi Matt this is Paula, there are no other questions. In that chat . Oh there is one more coming. There are no hands raised. There is a question being typed at this time. In the meantime there's a question from Pam. Her question , did the mail contractor snafu affect the letters should have received that we know of?
>> JULIET MARSALA: To answer that question for Pam, for that contacts for the larger group, and some of you may have seen the news releases about this, there was a delay in mail that occurred in November. That did impact information that goes out from the central processing area. Typically from the office of income maintenance, Bill was delayed from November 3 to December 3 in 2025 due to an issue with an external mail vendor. The agreement with that vendor was terminated. In the Commonwealth at large is working with a new vendor. Although Adelaide mail has been sent out. But certain individuals in certain programs they don't have all the details on that. They have received their notices and paperwork later than otherwise expected or may have received an additional notification. So ever since we became aware of the vendor's failure. We have worked around-the-clock to ensure that the participants we serve have received this communications as quickly as possible individuals who signed up for electronic notices, this did not impact any of those, that a lot of individuals use electronic notices, where possible and where we can given the authorities that we operate under, federal level and state level, we extended appeal deadlines by an extra 45 days and also extended due dates for renewals for those individuals that we believe may not have received timely mail about their benefits. And you know, individuals who may not have received their appeal notification of their appeal hearing DHS has been rescheduling all of those appeals and will contact all individuals impacted to reschedule the appeals anyone who believes they have been impacted but haven't received any additional information , certainly contact your caseworker and your local County assistance office. So I hope that would be helpful for folks. Leaders strongly

recommend if folks can do enroll in EE notices. That's the fastest way you will know and get information about what DHS may need to make an eligibility determination and to let you know what actions have been taken about benefits. So you know, if you sign up for the EE notices, you will still receive paper renewal packets abdominal. But it just gets you the information faster. I hope Pam had answered your question. And in the interest of time Paula, I will go straight into the next question. Because I know we only have one minute left. So the question was how do we survive while there are no contracts. Which I think implies a question but how does his business survive if the CHC MCO networks are close. As I imagine you may be a small business, I would recommend perhaps reaching out to the small business bureau agency for additional support with regards to your particular business and individual decisions related to your business operations. Back to you, Matt. We had two minutes left.
>> MATT SEELY: In the last two minutes I don't think we can answer any questions. So I have a question for you Juliet. This appeal situation seems to be a big problem for people. Why is it not at least the first appeal that people have I could not be automatic? So that participants even if they don't want to, they can at least see how the process would unfold. And understand the appeal process . Why could that just be automatic?
>> JULIET MARSALA: We may not have time for the answer but it's a good question to further discuss. I live with appeals, you give context to what appeal Ashley talked about, we appealing a service ? Are we appealing eligibility but the Department of human services? Every purchase of the entrance to collect information for appeals within their participant handbooks. That lays out the process for is it a CHC appeal, it lays out the process, and notifications of terminations, and provides information on how to do an appeal. So certainly, worthy to explore further on how we can improve the education on that. To be a better experience. In some of the appeal work and education sits with the office of long-term living other processes of appeals if it is with the DHS is with the Bureau of hearings and appeals.
>> MATT SEELY: It’s a complicated issue nonetheless. With that time is over. I will accept a motion to adjourn from just about anyone.
>> This is Kathy, I make a motion to adjourn.
>> MATT SEELY: Thank you Kathy. With that we will see you all next week. – – Next month. Thank you.
>> Thank you.